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Access to Healthcare and the Global Financial Crisis in Italy: A Human Rights Perspective

Acesso a cuidados de saúde e a crise financeira global em Itália: uma perspetiva dos direitos humanos

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ROSSELLA DE FALCO

ACCESS TO HEALTHCARE AND THE GLOBAL FINANCIAL CRISIS IN ITALY: A HUMAN RIGHTS PERSPECTIVE

Abstract: Equitable access to healthcare is fundamental in preventing health inequities, and it is warranted by international and regional norms on socio-economic rights. However, during financial crisis, pro-cyclical fiscal austerity can shift the cost of healthcare from the public onto the individual, impinging on the right of everyone to access timely and affordable healthcare. This article analyses this process through the case study of Italy, where the 2008 Great Recession catalysed a series of draconian budget cuts in the health sector. Using disaggregated survey data on self-reported unmet needs for healthcare, it will be shown that increased user fees and downsized health staff and facilities, combined with reduced disposable income, was associated with a drastic rise in inequities in accessing healthcare in Italy.

Keywords: access to healthcare; austerity; health inequities; Italy; right to health.

ACESSO A CUIDADOS DE SAÚDE E A CRISE FINANCEIRA GLOBAL EM ITÁLIA: UMA PERSPETIVA DOS DIREITOS HUMANOS

Resumo: O acesso equitativo aos cuidados de saúde é fundamental na prevenção das injustiças na saúde e é garantido por normas internacionais e regionais sobre direitos socioeconómicos. No entanto, durante uma crise financeira, a austeridade fiscal pró-cíclica pode transferir o custo dos cuidados de saúde do público para o indivíduo, afetando o direito de todos ao acesso adequado a cuidados de saúde. Este artigo analisa este processo através do estudo de caso da Itália, onde a Grande Recessão de 2008 catalisou uma série de cortes orçamentais draconianos, no setor da saúde. Usando dados desagregados de pesquisa sobre necessidades não atendidas de cuidados de saúde autorrelatadas, será demonstrado que o aumento das taxas de utilizador e a redução das equipas e das instalações de saúde, combinados com a redução do rendimento disponível, estiveram associados a um aumento drástico das desigualdades no acesso aos cuidados de saúde em Itália.

Palavras-chave: acesso aos cuidados de saúde; austeridade; injustiças na saúde; direito à saúde; Itália.

1. ECONOMIC CRISIS AND HEALTH SYSTEMS: AN OVERVIEW

In 2008, the United States subprime mortgage market entered a financial crisis, triggering one of the most severe global recessions since the 1930s. At first, policy-makers around the world unanimously carried out conventional countercyclical fiscal policies, increasing spending and rising taxes to revive aggregate demand. Supported by the International Monetary Fund (IMF) 37 countries (accounting for around 73% of the world) expanded public spending, resulting in an annual Gross Domestic Product (GDP) growth of 3.3% (Blanchard, 2008; Ortiz *et al.*, 2015). However, this also increased public debts. As a consequence, many governments turned to harsh austerity measures to restore public finances, either out of their own volition or under pressure from regional banks and international financial institutions (IFIs). Even if the rise in public deficits was largely a result of the crisis, the international community began looking at welfare states with suspicion, blaming overly generous welfare benefits for the global financial meltdown (*ibidem*). In this way, policies such as horizontal budget cuts, regressive reforms and large-scale privatisation became the new normal in policy-making circles, causing widespread socio-economic malaise in developed and non-developed countries alike (Chakraborty, 2016). Austerity measures can also result in socioeconomic rights' backsliding, with the most vulnerable groups bearing the heaviest burden of fiscal adjustment. In these particularly severe cases, economic recovery policies might constitute a *prima facie* violation of the International Covenant on Economic, Social and Cultural Rights – ICESCR (United Nations, 1967).

As many other fundamental rights, the right to health has been sternly affected by regressive fiscal measures. This is not surprising, as healthcare often occupies a huge share of public expenditure in most welfare states, and many governments reduced their health budgets (Mackenbach, 2013). This policy pattern was followed by the Italian government as well, with huge repercussions on healthcare accessibility. In fact, if progressive health policies, combined with inclusive social policies, can improve healthcare affordability, horizontal cuts might hinder equitable access to care (Sabine, 2016). Consistently, several waves of austerity undertaken by the Italian government are associated with an increase in unaffordable healthcare in Italy. For example, according to a medical association's report, in 2015, 12.2 million Italians, or one in five, went without medical care, while 7.8 million spent all their saving on healthcare or contracted a medical debt (CENSIS/RBM, 2018). In other words, the United Nations Committee on Economic, Social and Cultural Rights is fully backed by hard evidence when it expresses serious concerns over the enjoyment of the right to health in Italy (United Nations, 2015).

This paper analyses how the regressive fiscal measures that followed the 2008's global financial crisis exacerbated inequities in access to care throughout Italy. Thus, this

work points out to a potential backsliding in the enjoyment of the right to health, which Italy recognises not only by being a member of the ICESCR, but also through article 32 of its Constitution (Italian Republic, 1947). To this end, disaggregated European Union Statistics on Income and Living Conditions (EU-SILC) microdata on unmet medical needs will be scrutinised in detail, highlighting how disparities in accessing care have widened during the crisis. These data are disaggregated by socio-economic status, labour status, education attainment level as well as country of citizenship and of birth. Special attention will be also given to geographical differences between Italian regions.

Austerity is not the only alternative when it comes to economic recovery. Moreover, the negative effect of austerity on economic output and long-term unemployment have been widely discussed by heterodox and orthodox economists alike (Krugman, 2015; Stiglitz *apud* Hackwill, 2016). Bearing this in mind, the conclusions of this work will summarise the potential alternatives to austerity available to the Italian government, while also analysing the conduct of the Italian government in light of its human rights' obligations.

2. INEQUALITY, ACCESS TO CARE AND HEALTH INEQUITIES AT TIMES OF ECONOMIC CRISIS: A HUMAN RIGHTS FRAMEWORK

Equitable access to healthcare is one of the tenants of the right to the highest attainable standard of physical and mental health. In fact, article 12 of the ICESCR obliges member states to take steps towards “the prevention, treatment and control of epidemic, endemic, occupational and other diseases” as well as “the creation of conditions which would assure to all medical service and medical attention in the event of sickness” (United Nations, 1967: 6-7). Equitable access to healthcare, thus, is dependent upon the dimensions of availability and accessibility of healthcare goods and facilities (United Nations, 2000). Availability relates to the existence of healthcare facilities and essential medicines in proper quantity and of acceptable quality (*ibidem*). Accessibility, instead, is a multidimensional principle composed of the following elements: physical accessibility; economic accessibility (i.e. affordability); non-discrimination; and information accessibility.¹ In Europe, the warranty of fair and universal access to high-quality and timely healthcare is also provided by the Charter of Fundamental Rights of the European Union (European Union, 2012) and the European Social Charter (Council of Europe, 1996).

¹ These are two of the four dimensions composing the AAAQ (acceptability, availability, accessibility and quality) Framework for the right to health designed by the United Nations Committee on Economic, Social and Cultural Rights in its General Comment 14 (UN – CESCR 2000)

Notwithstanding the plethora of norms ensuring access to care, barriers in accessing healthcare are widespread across European countries. This is concerning, as equitable access to care is a key factor in preventing health inequities. In fact, if the promotion of the underlying determinants of health diminish socio-economic disparities in contracting an illness, enabling access to health eases inequities in surviving and healing from diseases (Costa, 2017). Therefore, to ensure the progressive realisation of the right to health and to combat health inequities, it is urgent to ensure that all individuals have universal access to timely care, with special attention to vulnerable groups.

Which factors cause inequality in accessing care? First, high levels of income inequality within socio-economic groups can result in massive health inequities. In fact, people living in poverty, or experiencing precarity on low-paid jobs, might forego care due to financial reasons. In “The Killing Fields of Inequality”, Therborn (2012) defines these kinds of socio-economic disparities as inequality “of resources”. Likewise, individual differences such as age, gender, nationality and country of birth can all generate significant gaps when accessing healthcare. These inequalities are defined as “existential” by Therborn (*ibidem*). Finally, regressive health policies might also undermine equitable access to care. For example, the 2008’s global financial crisis has prompted an increase of people lamenting unmet healthcare needs in the EU (Baeten *et al.*, 2018). This might be the result of the harsh austerity measures implemented in Europe after the global recession, with loss of entitlements for some groups and, at the same time, a higher need for healthcare due to the crisis (De Vogli, 2013, 2014; Loughane *et al.*, 2019).

3. METHODOLOGY

This paper investigates the vicious mechanism between austerity policies, structural inequalities and access to care through the case-study of a high-income Mediterranean country: Italy. In fact, Italy was hardly hit by the economic crisis, with severe repercussions on its healthcare system. After depicting the major healthcare reforms that followed the global financial crisis, inequitable access to healthcare is analysed through descriptive statistics. The key indicator used is “unmet needs for medical care” by reason, disaggregated by income quintile, labour status, educational attainment, country of birth and citizenship. This microdata is collected yearly by Eurostat within the EU-SILC survey, and they are freely accessible at aggregate level. Special attention will be given to the effect of being either a poor or a working poor on accessing healthcare. For the individuals that are excluded from official data, such as illegal migrants, qualitative data

will be used. As for data regarding geographical health inequities, the point of reference is the Italian National Statistics Office's database Health for All.²

As regards the theoretical premises underpinning the present work, this article builds on the vast literature on human rights measurement (Barsh, 1993; Landman and Carvalho, 2009; Ramirez, 2011; Hunt *et al.*, 2013) as well as health equity (Diderichsen *et al.*, 2001).

4. THE ITALIAN NATIONAL HEALTH SERVICE (NHS): A SYSTEM UNDER THREAT

The Italian NHS (Servizio Sanitario Nazionale – SSN) was founded in 1978, replacing the pre-existing social health insurance system. Based on the principles of universality, solidarity and financial protection, the system is funded by general taxation and provides automatic coverage to all citizens, legal foreign residents and migrants holding a residence permit. Thus, the institution of the Italian NHS realised, in principle, both the collective and the individual dimensions of the right to health, as enshrined by article 32 of the Italian Constitution. In fact, this article warrants that the right to health is “a fundamental right of the individual” as well as a “collective interest”, enabling “free medical care to the indigent” (Constitution of the Italian Republic, 1947, art. 32).

For years, this three-tiered system has delivered free, high-quality healthcare to those in need, gaining its position as the second best in the world in the WHO ranking (WHO, 2000). Of course, much room of improvement existed, as testified by the unsolved gap between Northern and Southern regions, combined with financial constraints plaguing the most vulnerable groups. However, subsequent reforms focused more on cost containment rather than easing health inequities. In fact, only ten years after the SSN was founded, user fees were introduced aside general taxation as an instrument to regulate healthcare demand and increase the efficiency of the system (Decree-Law 382/1989).³ By the same token, potential measures that impinged on health equity were introduced with law 347/2001,⁴ which established that single Italian regions can set different rules on user fees due to budget reasons. The gradual shift of health costs from the state to the individual has been further aggravated by the introduction of an additional fee on specialist visits (Decree-Law 111/2011;⁵ Cittadinanzaattiva, 2011).

² Health for All, Italy, software freely available at <https://www.istat.it/it/archivio/14562>. Accessed on 01.12.2019.

³ Decree-Law 382/1989, “Disposizioni urgenti sulla partecipazione alla spesa sanitaria e sul ripiano dei disavanzi delle unita' sanitarie locali (GU Serie Generale n.277 del 27-11-1989)”. Accessed on 01.12.2019, at <https://www.gazzettaufficiale.it/eli/id/1989/11/27/089G0457/sq>.

⁴ Decree-Law 347/2001, “Interventi urgenti in materia di spesa sanitaria”. Accessed on 01.12.2019 at <http://www.parlamento.it/parlam/leggi/decreti/01347d.htm>.

⁵ Decree-Law 111/2011, “Conversione in legge, con modificazioni, del decreto-legge 6 luglio 2011, n. 98 recante disposizioni urgenti per la stabilizzazione finanziaria (11G0153) (GU Serie Generale n.164 del 16-07-2011)”. Accessed on 02.12.2019, at <https://www.gazzettaufficiale.it/eli/id/2011/07/16/011G0153/sq>.

This is worrying, as raising user fees imply a trade-off between efficiency and equity (Rebba, 2009), threatening universal access to affordable healthcare.

4.1. THE 2008’S GREAT RECESSION AND AUSTERITY: A GLOBAL PHENOMENON

Before proceeding with the analysis of Italian health reform policies, it is necessary to link Italy’s decisions in policy making with the broader global turn towards spending contraction. Since 2010, in fact, most governments around the world have been implementing harsh austerity policies to achieve fiscal consolidation (Ortiz *et al.*, 2015). According to a recent estimate of the International Labour Organization (ILO), in 2018, 124 countries will be adjusting expenditures in terms of GDP; the number is expected to rise slightly in 2020 (Ortiz *et al.*, 2015: 2-6). This short-term adjustment process is supposed to affect nearly 80% of the global population (*ibidem*). Moreover, by 2020, an estimated 30% of countries in the world will be undergoing excessive fiscal contraction, defined as cutting public expenditures below pre-crisis levels, including countries with high developmental needs such as Angola, Eritrea, Iraq, Sudan and Yemen (*ibidem*).

As shown in Table 1, contractionary fiscal policies can be implemented either by reducing spending or increasing revenues. Measures aimed at reducing spending include budget cuts, regressive tax changes, labour reform and pension reform. Although less often implemented, outsourcing and privatisation have also been used by governments as a way of collecting short-term revenues and decreasing public deficits (Chakraborty, 2016).

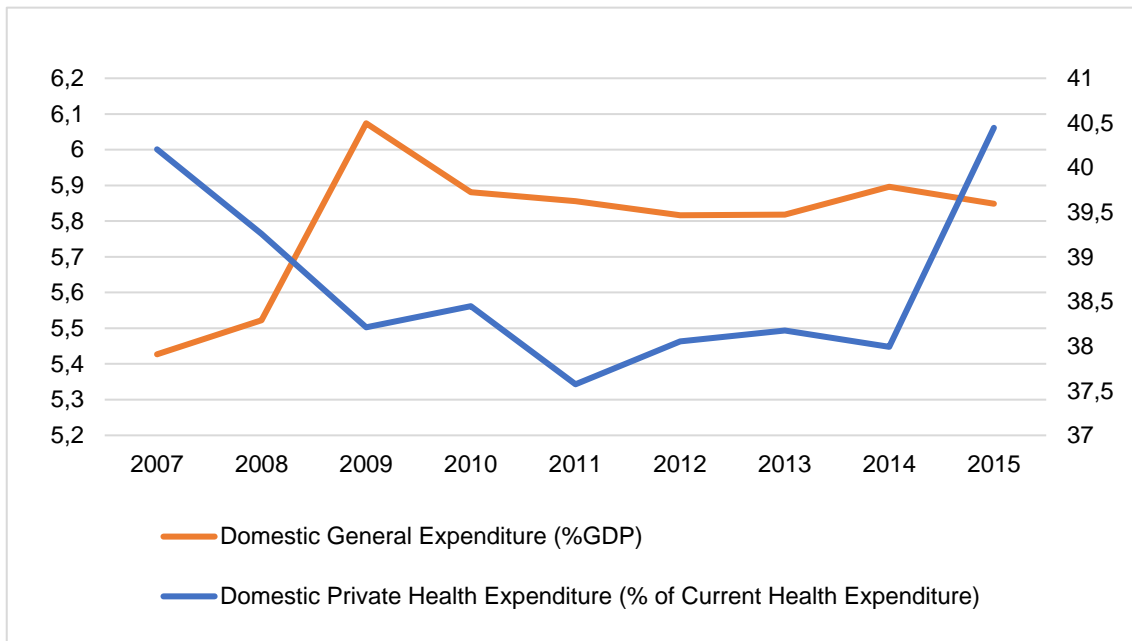
TABLE 1 – Major Fiscal Consolidation Measures Implemented or Under Consideration Worldwide

Reducing Spending	Collecting Revenues
<ul style="list-style-type: none"> • Eliminating or reducing subsidies • Wage bills cuts/caps • Rationalizing and further targeting social safety nets • Healthcare reforms • Old-age pensions reforms 	<ul style="list-style-type: none"> • Increasing taxes on goods and services (mostly Value added Taxes – VATs) • Privatisation of Public Services

Source: Elaboration by the author from Ortiz *et al.* (2015: 12-14) and CESR (2018: 14-15).

In line with this global retrenchment in public spending, health expenditure in Italy also began decreasing over the period 2008-2010. At the same time, as shown in Figure 1, private healthcare spending started increasing. This shift in public and private shares of healthcare costs will be now analysed in detail over the next paragraphs.

FIGURE 1 – Public (GDP, %) vs. Private Healthcare Spending (Current Health Expenditure – CHE, %), Italy



Source: Elaboration by the author from OECD – Organisation for Economic Co-operation and Development (2019), “OECD Health Statistics 2019”, July 2. Accessed on 23.05.2019, at <http://www.oecd.org/els/health-systems/health-data.htm>.

4.2. THE ECONOMIC CRISIS IN ITALY AND THE ADOPTION OF AUSTERITY MEASURES

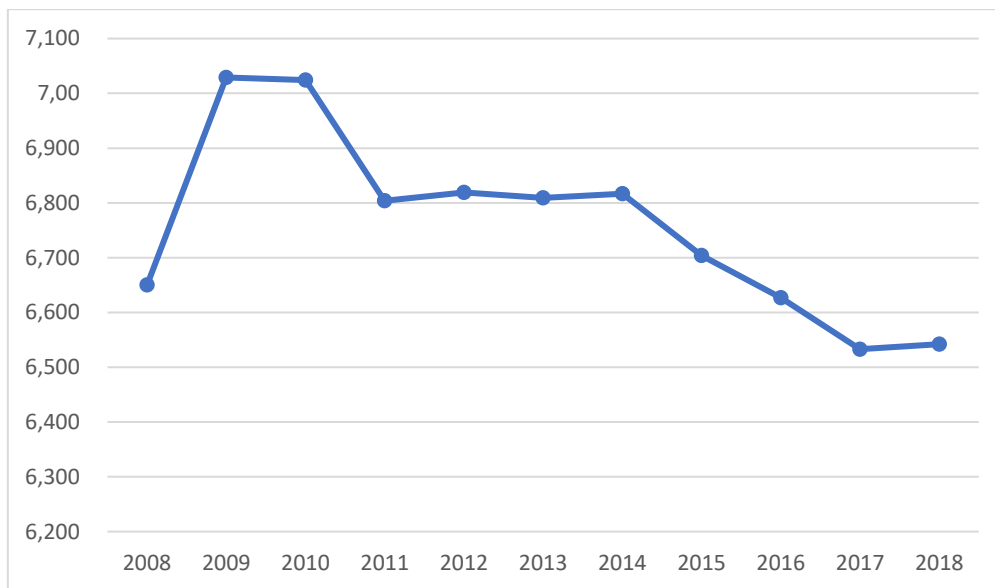
Italy's economic growth was already stagnant when the sovereign debt crisis struck the Eurozone. Additionally, Italy's public debt grew from 103% in 2007 to nearly 127% in 2012 (Petrelli, 2013). This escalation of the public debt compromised mutual trust between banks, dumping sovereign bond markets' confidence in Italy's recovery (*ibidem*). The consequent credit freeze pushed the country into a long-lasting recession, with widespread bankruptcies and companies' default (*ibidem*). Swiftly, the fear of contagion spread among the other major European economies. In fact, if the third largest European economy ended like Greece, the stability of the whole Eurozone would have been severely compromised.

On 5 August 2011, the Italian government received a letter by European Central Bank's leaders Mario Draghi and Jean-Claude Trichet. The letter was an offer of debt financing by the European Central Bank (ECB), given the implementation of the following reforms: large-scale privatisation; transferring of collective bargaining to undertakings; public sector pay-cuts; privatisation of public utilities; introduction of automatic correction mechanisms for deficits (Fischer-Lescano, 2014). Therefore, Italy's implementation of austerity policies was not the result of direct economic conditionalities attached to international rescue loans, as in the case of the Memorandum of Understandings (MoUs) signed by Greece with the institutions of the Troika (IMF, World Bank, and the ECB).

Rather, Italy reacted to an open letter by the ECB. The letter was made public by several newspapers, but it was not intended as an official document (*Corriere della Sera*, 2011). Because of the letter, then-Prime Minister Silvio Berlusconi resigned. Soon after, in 2011, a bipartisan governmental coalition guided by the renowned academic and economist Mario Monti implemented a series of policy actions aimed at avoiding a Greek-style public debt collapse in Italy.

4.3. ITALIAN AUSTERITY POLICIES IN THE FIELD OF HEALTHCARE (2010-2016)

FIGURE 2 – Public Health Expenditure (% GDP), Italy (2008-2018)



Source: Elaboration by the author from OECD – Organisation for Economic Co-operation and Development (2019), “OECD Health Statistics 2019”, July 2. Accessed on 02.12.2019, at <http://www.oecd.org/els/health-systems/health-data.htm>.

Over the 2008-2010 period, Italy froze public spending on health. In fact, the average annual growth of health spending was 6% between 2000 and 2007, but only 2.3% over the period 2008-2010 (*La Repubblica*, 2013). As shown in Figure 2, in 2010, Italian health spending abandoned its decennial positive trajectory and began a gradual, yet steady, decrease (DEF, 2017). At the same time, funds for essential medicines and the National Health Fund were reduced, amounting to an overall budget cut of €4.15 billion in 2012.⁶ Co-payments for outpatient drugs and prescribed procedures/specialist visits (Gabriele, 2015) have also grown by 53.7% (real terms) over the 2007-2015 period (CENSIS/RBM, 2018). In this context, funds for guaranteed free pharma decreased by 660 million, while expenditure for hospitals by 880 million (*ibidem*). Additionally, the Italian Ministry of

⁶ See Stability Law 228/2012, “Disposizioni per la formazione del bilancio annuale e pluriennale dello Stato (Legge di stabilita’ 2013)” (12G0252) (GU Serie Generale no. 302 del 29-12-2012 – Suppl. Ordinario no. 212). Accessed on 01.01.2019, at <http://www.gazzettaufficiale.it/eli/id/2012/12/29/012G0252/sg>.

Economics and Finance has recently predicted that health spending will further diminish over the period 2018-2020, slumping as low as 6.4% of the GDP (DEF, 2017). This is even more concerning when comparing Italian levels of public health spending with those of the rest of Europe. In fact, Italy performs far worse than countries of comparable GDP size, such as France and Germany (OECD, 2016).

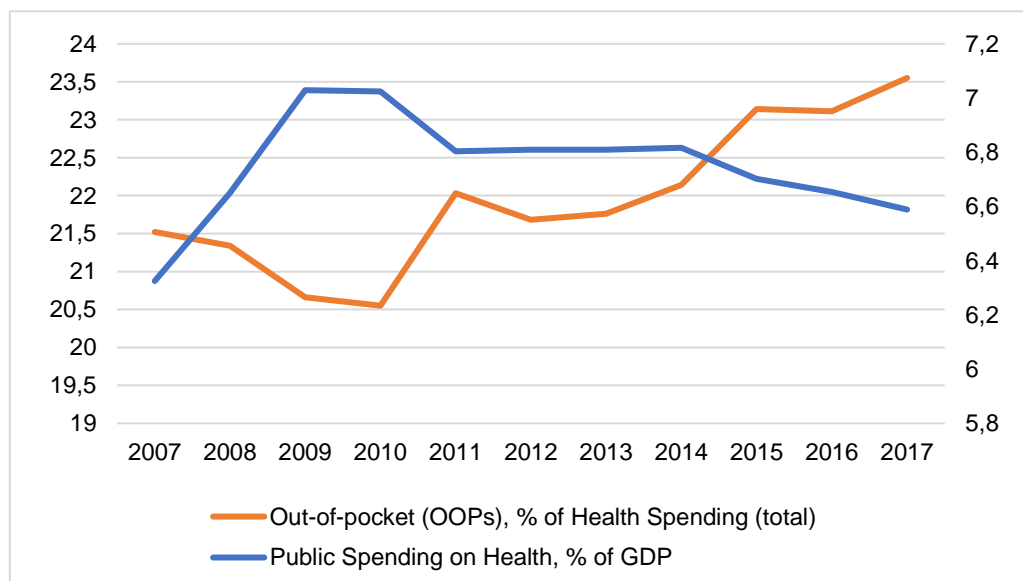
4.4. THE IMPACT ON HEALTHCARE ACCESSIBILITY AND AVAILABILITY

The austerity measures implemented by the Italian government in the field of healthcare have impacted multiple dimensions of the right to health: accessibility, availability, quality and acceptability. As this paper is concerned with equitable access to care, only the dimensions of accessibility and availability of healthcare will be analysed. Therefore, below it will be analysed how austerity measures impacted: out-of-pocket payments (OOPs); healthcare facilities; waiting lists.

4.4.1. OUT-OF-POCKET PAYMENTS

OOPs are direct payments made by individuals to healthcare providers. High levels of OOPs might create an access barrier and put affordability of healthcare at risk. As such, they represent a human rights indicator that pictures well the level of affordability of healthcare systems. Empirical research has also shown that, at global level, the less a government spend on health, the more the healthcare system tends to rely on OOPs (Mclsaac *et al.*, 2018).

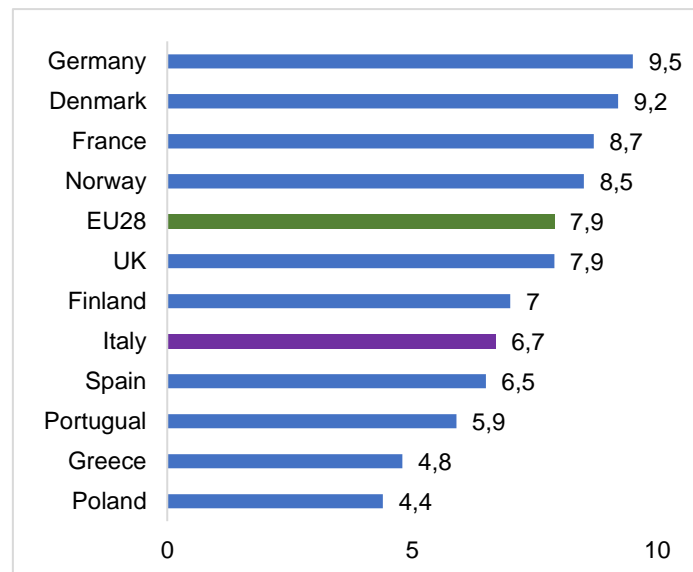
FIGURE 3 – Reliance on Out-of-Pocket Payments vs Government Spending on Health (% of GDP), Italy, (2007-2017)



Source: Elaboration by the author from OECD – Organisation for Economic Co-operation and Development (2019), “OECD Health Statistics 2019”, July 2. Accessed on 23.05.2019, at <http://www.oecd.org/els/health-systems/health-data.htm>.

As Figure 3 shows, after the implementation of the first round of austerity measures (2010), user fees (OOPs) as a percentage of current health spending began rising, showing a negative correlation to the decrease in the governmental share. After six years of fiscal contraction, the percentage of OOPs reached 23%, or one fifth of the overall expenditure on health (OECD and European Observatory on Health Systems and Health Policies, 2017). As a way of comparison, in 2014, Italian user fees and co-payments resemble the ones in Greece and Spain, being above EU's average and doubling those of France. This is clearly shown in Figure 4.

FIGURE 4 – Public Health Expenditure, % of GDP, Selected European Countries (2014)



Source: Elaboration by the author from: OECD – Organisation for Economic Co-operation and Development (2019), "OECD Health Statistics 2019", July 2. Accessed on 23.05.2019, at <http://www.oecd.org/els/health-systems/health-data.htm>.

4.4.2. WAITING LISTS

According to the European Social Policy Network (ESPN), long waiting times are a common source of discontent among all European citizens. Excessively long waiting times can also foster inequities in accessing care, as high-income patients tend to bypass waiting lists in the public sector by consulting a private specialist, paying additional fees (Baeten *et al.*, 2018). Likewise, informal, under-the-table payments are a common practice in several European countries (*ibidem*).

On a similar pace, excessive waiting lists have been widely documented throughout Italy by independent agencies (CENSIS/RBM, 2018). However, states have started collecting data on waiting lists only recently. Therefore, a systematic diachronic analysis is not possible in this case. As it can be seen from Table 2 and Table 3, in any case, average waiting times (in days) have been rapidly growing over the 2014-2017 period, according to an independent investigation by CENSIS/RBM (*ibidem*). Table 3 also shows

different waiting times for private and public facilities, unveiling huge discrepancies. This data, however, have the limitation of coming from a report of two private entities (RBM⁷ and Censis⁸), rather than from a peer-reviewed academic journal, or official statistics. Therefore, they have to be taken with a grain of salt.

TABLE 2 – Waiting Times (in Days) National Average, by Type of Visit, Selected Years

	2014	2015	2017
Oculist Visit	61,3	62,8	88,3
Orthopaedical Visit	36,4	42,6	55,6
Colonoscopy	69,1	78,8	96,2

Source: Elaboration by the author from CENSIS/RBM (2018: 54).

TABLE 3 – Waiting Times (in Days), National Averages, by Type of Visits, Public vs Private Sector

	Public	Private
Gastroscopy	88,9	10,2
Colonoscopy	96,2	10,2
Echocardiography	70,3	5,9
Electromyography	62,2	6,2

Source: Elaboration by the author from CENSIS/RBM (2018: 54).

4.4.3. HEALTHCARE FACILITIES: HOSPITALS AND HOSPITAL BEDS

Shortages of healthcare facilities can result in increased waiting times for treatment or costs associated to travel longer distances. This is a risk for Italy, where both hospitals and hospital beds have been significantly downsized during the crisis. In fact, hospitals went from 1.271 in 2007 to 1.115 in 2015 (OECD, 2018a), with a total loss of 156 hospitals. At the same time, hospital beds per 1000 inhabitants went from 3.9 in 2007 to 3.2 in 2017. In Italy, however, this negative trend, however, initiated far before the crisis.⁹

⁷ For information on the insurance company RBM, please see: <http://www.finmeccanica.rbmsalute.it/chisiamo-eng.html> (last accessed on 02.12.2019).

⁸ For information on the Social Research Foundation Censis, please see: <http://www.censis.it/> (last accessed on 02.12.2019).

⁹ For OECD data on Hospital Beds, see: <https://data.oecd.org/healthqt/hospital-beds.htm> (last accessed on 02.12.2019). Indicator Name: OECD (2019), Hospital beds (indicator). DOI: 10.1787/0191328e-en

4.5. IMPACT ON ACCESS TO HEALTHCARE: WIDENED INEQUITIES

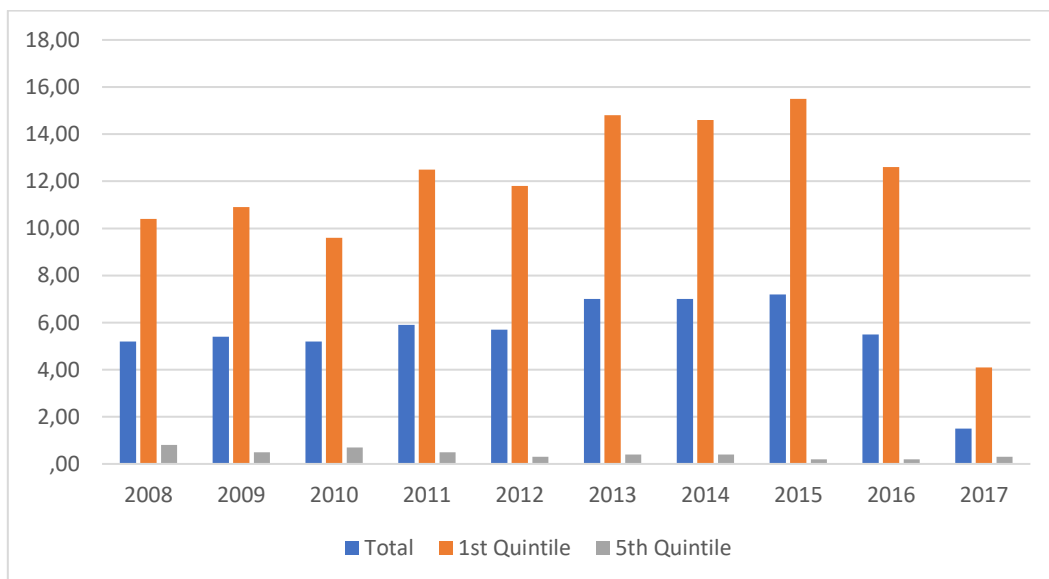
Horizontal budget cuts had a substantial impact on access to healthcare. However, the impact has been far more severe for the more disadvantaged groups in the Italian society, whereas those that were already better-off were barely touched from the crisis regarding their access to healthcare. This section investigates in detail how differences in terms of socioeconomic, labour, education attainment status and country of origin are associated with lower or higher healthcare access barrier.

4.5.1. SOCIOECONOMIC STATUS

Financial barriers, such as user fees and co-payments, constitute a serious concern for lower income groups. Moreover, medium and low-income patients face severe barriers in accessing healthcare timely when the public sector is plagued by excessively long waits (Landi, 2013; Petrelli *et al.*, 2012). Bearing this in mind, this section explores how socioeconomic status can determine unequal access to healthcare at times of crisis.

As Figure 5 shows, the impact of regressive fiscal consolidation measures has been unevenly distributed across income groups over the 2008-2017 period.

FIGURE 5 – Unmet Needs for Medical Care, “Too Expensive, Too Far to Travel or Waiting List”, by Income Quintile (% of the total population), Italy, 2008-2017



Source: Elaboration by the author from Eurostat, “European Union Statistics on Income and Living Conditions (EU-SILC)”. Accessed on 23.05.2019, at <https://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions>.

As it can be seen in the figure above, since the start of the crisis, the percentage of people in the lowest quintile suffering from unmet medical needs had been steadily growing, becoming as high as 15.5% in 2015. By contrast, the number of people in the

highest quintile reporting foregone care was below 1% over the period 2008-2017 and it has also diminished during the period of the crisis. Clearly, the most vulnerable socio-economic group was bearing the heaviest burden of contractionary fiscal policies. Reinforcing this evidence, a recent study has yielded that, in Italy, people that are at risk of poverty or experience severe material deprivation are more likely to renounce to healthcare (Gaudio *et al.*, 2017). Moreover, the likelihood is higher for people living in the Islands, in the South and for foreigners (*ibidem*).

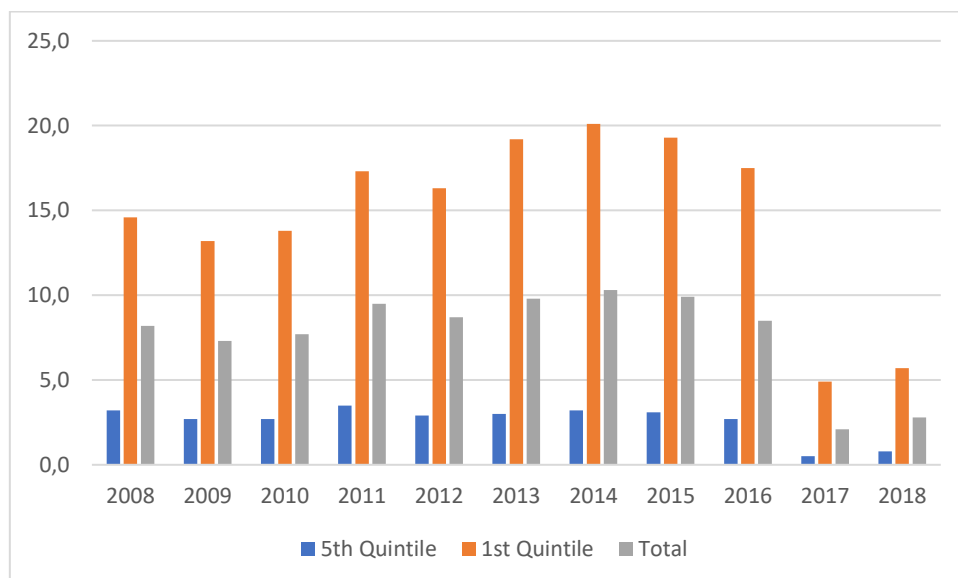
TABLE 4 – Unmet Needs for Dental Care, “Too Expensive”, (%), Difference between Pre and Post Crisis Levels – Low-Income vs High-Income Earners

	2008	2016	Difference
Bottom 20%	14.6	17.5	+ 2.9%
Top 20%	3.2	2.7	- 0.5%

Source: Elaboration by the author from Eurostat, “European Union Statistics on Income and Living Conditions (EU-SILC)”. Accessed on 23.05.2019, at <https://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions>.

Unmet needs for dental care show a similar pattern as shown in Table 4 and Figure 6. In Table 4, it can be seen that unmet needs for dental care due to financial reasons rose by almost 3% for the poorest income quintile, while they even reduced by 0.5% for the better-off.

FIGURE 6 – Unmet Needs for Dental Care, ‘Too Expensive, Far to Travel or Waiting List’, by Income Quintile, Italy, % of Total Population



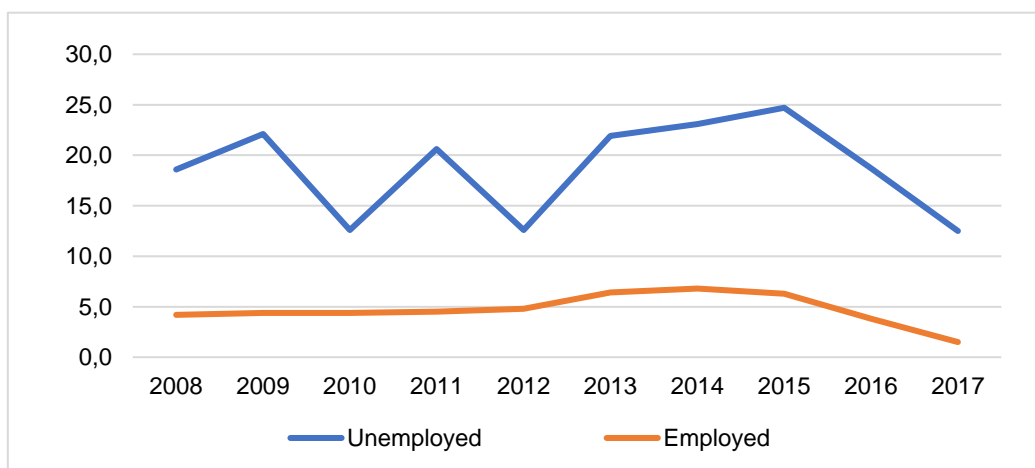
Source: Elaboration by the author from Eurostat, “European Union Statistics on Income and Living Conditions (EU-SILC)”. Accessed on 23.05.2019, at <https://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions>.

Figure 6, instead, shows unmet needs for dental care due to all reasons over time. The figure shows that, in 2008, 14.6% of the Italians in the poorest quintile could not afford dental care, reaching 20.1% in 2014 and remaining high, at 17.5%, in 2016. Differently, the top earners self-reported no significant increase during the years of the crisis. Special attention should be given to old people, who are particularly affected by access barrier for dental care. In fact, according to a report by the Italian National Statistics Office, only 29.2% of people aged 75+ accessed dental care in 2015, against the European average of 45.3% (ISTAT, 2015a).

4.5.2. EMPLOYMENT STATUS

The employment status can also determine inequalities in accessing care. For example, the growth in occupational health insurance coverage may increase inequalities in access to healthcare; this because the amount of occupational welfare benefits depends strongly on companies' characteristics such as size and productivity and can galvanize health inequities when it comes to access healthcare services (Baeten *et al.*, 2018). Troublingly, voluntary and occupational health insurance may also lead to shortage of public healthcare, as they encourage NHS' doctors to join the private sector (*ibidem*).

FIGURE 7– Unmet Needs for Healthcare, “Too Expensive, Far to Travel or Waiting List”, Unemployed vs Employed Persons, % of people aged 55 to 64, 2008-2017, Italy



Source: Elaboration by the author from Eurostat, “European Union Statistics on Income and Living Conditions (EU-SILC)”. Accessed on 23.05.2019, at <https://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions>.

Figure 7 displays that, during the crisis, the proportion of Italian unemployed people declaring unmet medical needs is much higher than employed persons. For example, in 2008, unmet medical needs for unemployed people aged 55-64 were three times higher than those of employed ones. This inequality has widened over time the period 2008-2017, with employed people showing only a minor increase.

4.5.3. EDUCATIONAL ATTAINMENT

The level of education can hugely influence access to care too. For example, lack of information and social networks can limit the auto-detection of severe illnesses. It has been proven, in fact, that for lack of knowledge, marginalisation and lack of social support's networks can delay essential surgical operations such as hip replacement or cataract (Petrelli *et al.*, 2012).

TABLE 5 – Unmet Needs for Medical Care, “Too Expensive, Far to Travel or Waiting List”, by Level of Educational Attainment, (%),2014, Italy

	Total	Medical care	Dental care	Mental healthcare	Prescribed medicines
People with Primary Level of Education or Less	19,9	14,6	17,9	3,7	8,9
People with Tertiary Level of Education	10,5	7,4	8,8	2,6	4,5

Source: Elaboration by the author from Eurostat, “European Union Statistics on Income and Living Conditions (EU-SILC)”. Accessed on 23.05.2019, at <https://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions>.

Table 5 summarises EU-SILC survey data for 2014, disaggregated by level of education attainment. Individuals with lower levels of education lament higher unmet medical needs in comparison to those that accomplished higher levels of education, such as a university degree. Under EU-SILC, the education attainment levels of survey respondents are classified according to the 'International Standard Classification of Education', version of 2011 (UIS, 2012), so that data are harmonised for comparison between different countries.¹⁰

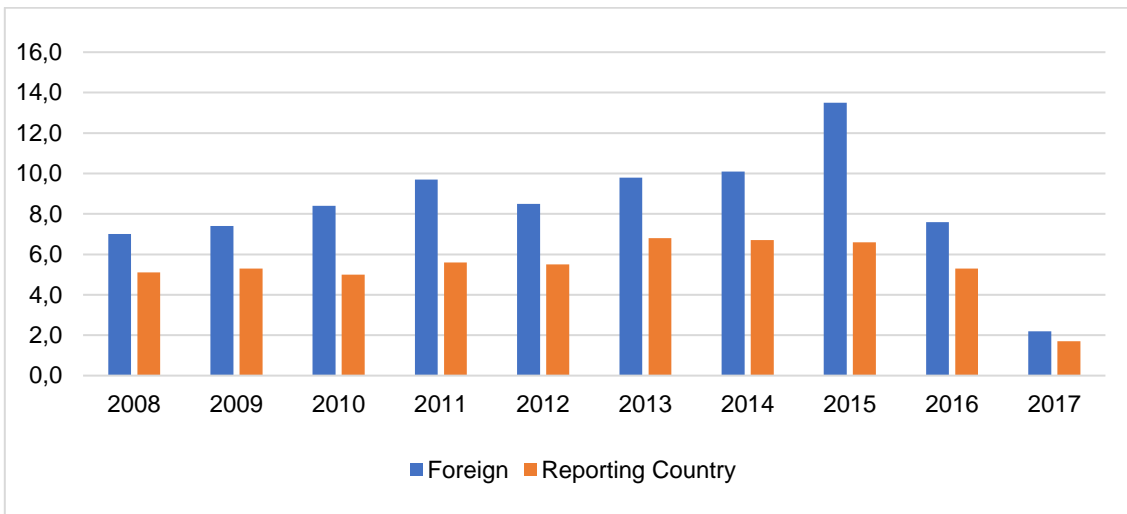
4.5.4. COUNTRY OF CITIZENSHIP

The Italian NHS offers free medical care to all legal residents and migrants holding a permit.¹¹ However, Italian citizens and foreigners access healthcare differently, according to Eurostat's data. As it is shown in Figure 8, these differences widened throughout the crisis, skyrocketing in 2015, while remarkably easing in 2017.

¹⁰ Metadata for the EU-SILC survey is available at: https://ec.europa.eu/eurostat/cache/metadata/en/ilc_esms.htm#meta_update1508767944514 accessed on 02.12.2019).

¹¹ This was disciplined by Law 40/1998 on migration.

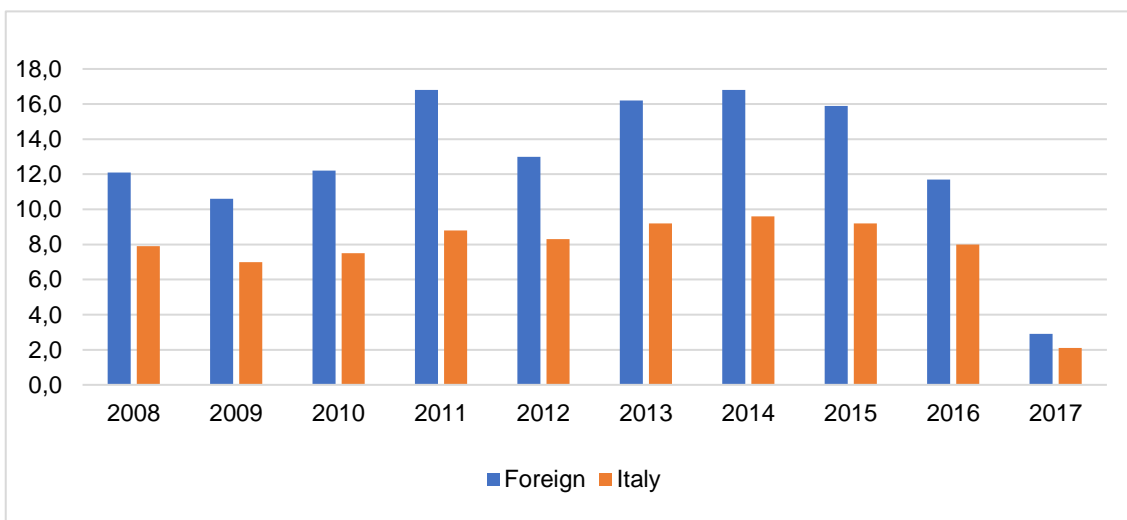
FIGURE 8 – Unmet Needs for Medical Care, by Citizenship, “Too Expensive, Far to Travel or Waiting List”, (%), Italy



Source: Elaboration by the author from Eurostat, “European Union Statistics on Income and Living Conditions (EU-SILC)”. Accessed on 23.05.2019, at <https://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions>.

Similar trends are observed when looking at the country of birth, rather than citizenship. In fact, access barriers lamented by those being born in another country are on average higher with respect to those having a different citizenship. These trends are shown for years 2008-2017 in Figure 9.

FIGURE 9 – Unmet Needs for Medical Care, by Country of Birth, “Too Expensive, Far to Travel or Waiting List”, (%), Italy



Source: Elaboration by the author from Eurostat, “European Union Statistics on Income and Living Conditions (EU-SILC)”. Accessed on 23.05.2019, at <https://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions>.

Potential barriers in accessing healthcare services by the migrant population may be related to cultural differences, communication problems, administrative barriers as well as the personal inclinations of the health staff (Hernandez-Quevedo, 2012).

Within those people not having an Italian citizenship or not being born in Italy, there are some groups that are totally excluded from public health services, and that do not figure in officials' statistics. This is the case of the migrants not holding a residence permit, who are being increasingly marginalised, facing extremely high costs in terms of morbidity and mortality. There are also some migrants that hold a residence permit but live in marginalised areas in the suburbs of a metropolis or in rural, semi-abandoned areas due to an incomplete inclusion process. This is especially common in the case of "economic" migrants (MSF, 2018). According to a leading medical non-governmental organization (*ibidem*), these individuals are deprived not only of the right to healthcare, but also of access to proper shelter, water, sanitation and food (Camilli, 2018).

By the same token, another group of people that is particularly exposed to health risks and access barrier are the Roma and Cinti ethnic minorities. Although these people have legal access to the services, strong barriers remain when it comes to the use of their right to timely health care (European Commission, 2004). For all these minorities present on the Italian territories, the economic crisis represents a source of concern because of the populist parties, which ride the wave of popular discontent and galvanise discourse of hate against foreigners in Italy.

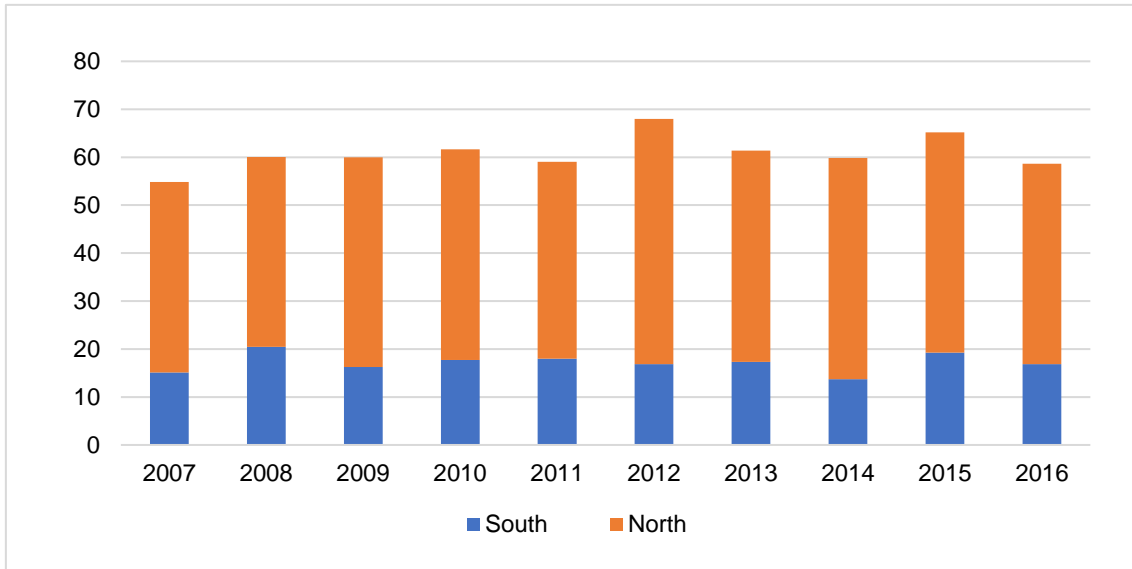
4.6. GEOGRAPHICAL HEALTH INEQUITIES: THE NORTH-SOUTH GAP

In 2006, the Italian NHS was destabilised by the growing public deficits of many regional systems. To avoid widespread financial failure, the government required overspending regions to adopt and implement formal recovery plans – *Piani di Rientro* (De Belvis *et al.*, 2012). Since 2007, 10 out of 21 regions ran these plans, being required to address the structural determinants of healthcare costs in their territories.¹² Combined with successive austerity measures, this fragmentation of the Italian NHS might play a substantial role in explaining the geographical health inequities (ISTAT, 2015b). In fact, many districts in the South, as well as some in the rest of Italy, are struggling to meet the minimum levels of assistance (LEAs) guaranteed by law (Grazzini, 2018). The percentage of people satisfied with healthcare treatments embodies the gap between Northern and Southern regions in Italy. For example, in 2013, 65.3% of people in the South declared they were satisfied of their last specialist visit, against the 77.2% in the North (ISTAT, 2015b). The gap widens consistently when looking at satisfaction for

¹² Piemonte, Liguria, Abruzzo, Molise, Campania, Lazio, Puglia, Calabria, Sicilia and Sardegna.

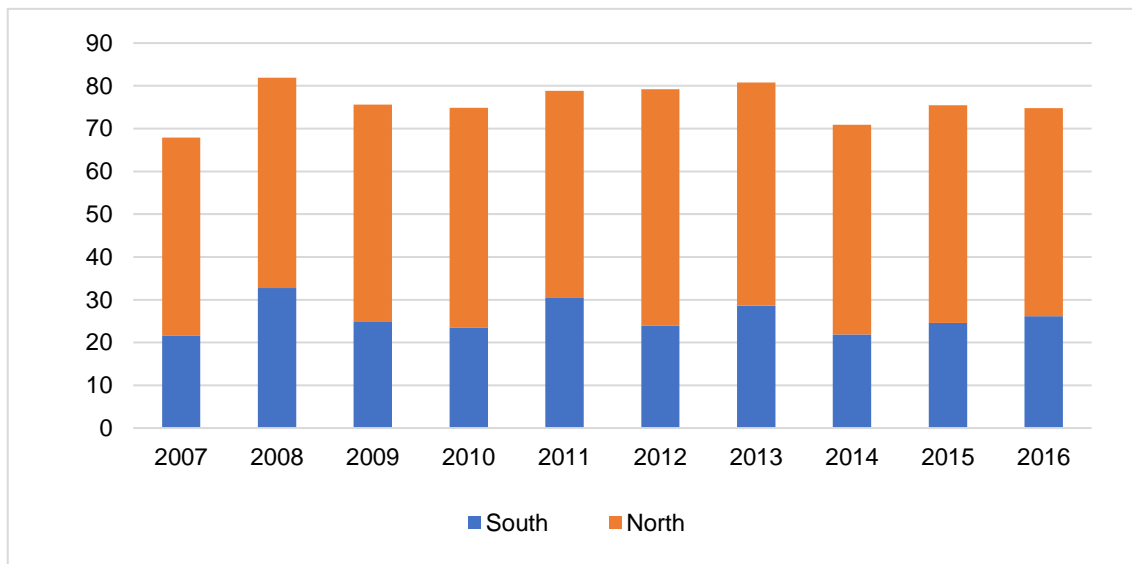
sanitation services inside hospitals, with 51% of the population in the North being satisfied in 2012, and only 16.9% of people in the South. These trends are displayed in Figure 9. In Figure 10, instead, similar trends can be observed regarding the satisfaction from medical and nursery assistance during hospitalisation (*ibidem*).

FIGURE 10 – People Satisfied with Hospitals’ Sanitation, North-South Divide, Italy (%)



Source: Elaboration by the Author from ISTAT, Annual Report (ISTAT, 2015b)

FIGURE 11 – People Satisfied by Medical Assistance during Hospitalisation, North-South Divide (%)



Source: Elaboration by the Author from ISTAT, Annual Report (ISTAT, 2015b)

These differences can be also seen through health expenditure per capita. In Table 6, it can be seen that health expenditure per capita in the Northern regions are higher

than in Southern ones. Moreover, Table 6 shows that this indicator has increased over the 2008-2016 period in the North. By contrast, it diminished in the South, even if slightly.

TABLE 6 – Current Health Expenditure Per Capita (in euros), North-South Comparison, 2008-2016, Italy

	2008	2016
North of Italy	1794.62	1868
South of Italy	1780.69	1778

Source: Elaboration by the Author from ISTAT, Annual Report (ISTAT, 2015b).

5. CONCLUSIONS

This paper has shown that healthcare access had diminished over the 2008-2017 period in Italy. Furthermore, disadvantaged groups also lament higher levels of unmet medical needs when disaggregating by: socioeconomic, labour and educational attainment status; country of citizenship and origin; age; geographical provenience. Draconian austerity measures, thus, are threatening the enjoyment of the right to health in Italy. In effect, austerity measures can amount to deliberative retrogressive measures, potentially breaching a country's obligations in respecting the socioeconomic rights of its citizens (Bilchitz, 2014; Salomon, 2015).

According to human rights law, austerity measures, resulting in severe socioeconomic rights' backsliding, are permitted only if they are the last resort (Bilchitz, 2014). However, austerity is far than unavoidable. The negative effect of austerity on long-term output and employment levels been widely discussed by heterodox and orthodox economists alike (Stiglitz *apud* Hackwill, 2016; Krugman, 2015). In Europe, the cases of countries such as Iceland, Switzerland and Portugal (after 2013) show how economic recovery can be realised in line with international human rights law, without renouncing to efficiency and financial viability.

Looking at the Italian economy, alternatives to austerity to reduce the debt-to-GDP ratio or to boost revenues include: financing at least a segment of the sovereign debt through bank loans, instead of financial markets' lending (Werner, 2014); combating fiscal evasion, increasing the progressivity of the Italian taxation system, sheltering low and middle-income households from the worst impacts of the crisis. Thus, if many alternatives to harsh regressive measures do exist, it might be that some of the economic recovery policies undertaken by the Italian government were another deliberate "assault on universalism" (McKee and Stuckler, 2011: 1).

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